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Issue Date: 13 June 2005

CASE NO. 2004-BLA-6611

In the Matter of

TOLBY LESTER,
Claimant

v.

K & N COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

William L. Roberts, Esquire
For the Claimant

Normal Harned, Esquire
For the Employer

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER-AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by Tolby Lester, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq*. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on October 26, 2001(DX 3), the new regulations are applicable (DX 77).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on December 7, 2004 in Abingdon, Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder. Director's Exhibits 1 through 77 were admitted into evidence, except for Director's Exhibit 60, which was withdrawn (TR 8). Furthermore, the record was held open for the submission of post-hearing evidence and closing arguments (TR 29-30). Under cover letter, dated February 4, 2005, Employer's counsel submitted various reports from Dr. Wiot, including a rereading of a chest x-ray dated June 22, 2004, an interpretation of a CT scan, dated November 5, 2004, a report, dated February, 2005; and, an American Board of Medical Specialties internet listing of the certifications/specialties of Dr. Forehand. All of the foregoing submissions have been jointly marked and received in evidence as Employer's Exhibit 4 (EX 4). Pursuant to my Order Granting Claimant's Motion to File Rehabilitative Evidence, dated February 25, 2005, Dr. Forehand's report, dated February 18, 2005, which was submitted by Claimant's counsel under cover letter, dated February 22, 2005, has been marked and received in evidence as Claimant's Exhibit 5 (CX 5).

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 77, except Director's Exhibit 60, which was withdrawn (TR 8; DX 1-59, 61-77), Employer's Exhibits 1 though 4 (EX 1-4), and Claimant's Exhibits 1 through 5 (CX 1-5). Moreover, in his letter dated March 4, 2005, Employer's counsel further clarified the medical evidence upon which Employer relies. In addition, the parties' respective briefs, which were filed on or about March 7, 2005 and March 15, 2005, have been received and considered.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

Claimant, Tolby Lester, filed an initial application for Federal black lung benefits on June 12, 1981, which was denied by the District Director's office on November 25, 1981 (DX 1). In the denial letter, the District Director's office stated, in pertinent part:

You do not qualify for benefits because the evidence in your claim

- does not show that you have pneumoconiosis (black lung disease);[2]

- does not show that you are totally disabled by the disease. Totally disabled means you are unable to perform the type of work required by your coal mine work because of a breathing impairment caused by pneumoconiosis (black lung disease). The results of your medical evidence are shown on the enclosed explanation.

(DX 1). Since Claimant did not appeal or take any further action within one year of the District Director's denial, the above referred claim is deemed finally denied and administratively closed (DX 1, 75).

On October 26, 2001, Claimant filed the current application for black lung benefits under the Act (DX 3). Following various procedural delays, a formal hearing was held before Administrative Law Judge Daniel F. Solomon on September 10, 2003 (DX 62). Subsequently, on September 12, 2003, Judge Solomon issued an Order of Remand, in which he cited evidentiary problems, and remanded the case in the "interests of justice and judicial economy" (DX 63). Claimant appealed the Order of Remand (DX 64). However, Employer and the Director moved for the dismissal of Claimant's appeal of Judge Solomon's interlocutory order (DX 68, 69). Thereafter, on October 31, 2003, the Benefits Review Board dismissed Claimant's appeal (DX 70). On remand, the District Director issued a Revised Proposed Decision and Order, dated April 6, 2004, awarding benefits (DX 71). On or about July 27, 2004, this matter was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 74-77). As stated above, a formal hearing was held on December 7, 2004. The record was closed following my receipt of the parties' post-hearing evidence and briefs.

Issues

The contested issues are as follows:

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations.
II. Whether the miner's pneumoconiosis arose out of coal mine employment.
III. Whether the miner is totally disabled.
IV. Whether the evidence establishes a material change in conditions per 20 C.F.R. §725.309.

(DX 74; TR 5-6).

Although the above-listed issues were identified by the parties' respective counsel as contested (DX 74; TR 5-6), I find that the crux of this case rests on whether the new evidence

[2] The only medical evidence contained in the initial claim is a positive (1/1) x-ray reading by Dr. Sutherland, dated August 6, 1980 (DX 1). It is, therefore, quite puzzling that the District Director's office cited the absence of pneumoconiosis as one of the bases for denying the prior claim (DX 1). However, whether or not the District Director erred in citing the "pneumoconiosis" issue in the initial claim is inconsequential. Furthermore, I accord little weight to the 1980 positive x-ray reading of Dr. Sutherland, in view of the progressive and irreversible nature of pneumoconiosis, and the fact that Claimant continued to be gainfully employed as a coal miner until 1998.

submitted in connection with this subsequent claim establishes the presence of *complicated* pneumoconiosis and/or total disability. As set forth below, the overwhelming preponderance of the medical evidence clearly establishes, at least, simple pneumoconiosis. Furthermore, Employer has not rebutted the presumption that the disease arose from Claimant's more than ten years of coal mine employment. Moreover, as discussed below, I also find that the preponderance of the evidence establishes *complicated* pneumoconiosis and total disability due to pneumoconiosis. Therefore, Claimant has also established a change in an applicable condition of entitlement under §725.309(d)(2), (3).

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Length of Coal Mine Employment

The parties stipulated, and I find, that Claimant engaged in coal mine employment for 32.163 years (DX 73; TR 5). Furthermore, I find that any discrepancy in the exact number of years of coal mine employment is inconsequential for the purpose of rendering a decision herein.

B. Date of Filing

Claimant filed his current subsequent claim for benefits under the Act on October 26, 2001 (DX 3). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). Employer concedes, and I find, that the claim was timely filed (DX 74).

C. Responsible Operator

Employer, K & N Coal Company, is the properly designated responsible operator in this case, under Subpart G, Part 725 of the Regulations (DX 4, 74; TR 27).

D. Dependent(s)

Claimant has one dependent for the purpose of possible augmentation of benefits under the Act; namely, his wife, Delores Lester (nee Stiltner). (DX 3, 12; TR 26-28).

E. Personal and Employment History

Claimant, Tolby Lester, was born on January 25, 1947. As stated above, Claimant has established one dependent under the Act, and that he engaged in coal mine work for 32.163 years.

The record reveals that Claimant has testified on at least four occasions in the current black lung claim. He initially testified at a deposition held on February 12, 2003 (DX 53). Subsequently, Claimant testified at the formal hearing before Judge Solomon on September 10, 2003 (DX 62). Claimant also testified at a second deposition on November 2, 2004 (EX 1).

Finally, Claimant testified at the formal hearing before the undersigned on December 7, 2004 (TR 25-28).

Taken as a whole, Claimant's testimony establishes that he ceased working as a coal miner on September 30, 1998, when he suffered a work-related accident, which resulted in broken ribs and a back injury. However, Claimant also noted that he had been suffering from shortness of breath for many years prior to the accident. On the other hand, Claimant had worked regularly, often 60-70 hours per week, before the accident (DX 53, p. 9; DX 62, pp. 13-14; EX 1, pp. 5-8; TR 27). Claimant has received a lump sum settlement for his work-related accident (DX 53, pp. 19-20), and receives Social Security disability benefits (DX 62, p. 15). Claimant has been treated by Dr. Initiaz Hussain for his breathing problems (TR 28; DX 62, pp. 12-13; *see also* CX 2). Claimant had previously seen a different Dr. Hussain (DX 53, p. 33; DX 62, pp. 20-21; EX 1, p. 13). Claimant has never smoked (DX 53, p. 16; DX 62, p. 13).

Claimant's last usual coal mine job entailed a combination of various duties. On the Employment History form, dated November 21, 2001, Claimant listed his last job as "Scoop man & mechanic" (DX 5). Furthermore, on the Description of Coal Mine Work and Other Employment form, dated October 26, 2001, Clamant listed the job title as "General Inside Laborer," but described the job duties as follows: "Mechanic, ran equipment – did most all jobs. I worked inside." (DX 6). The job entailed some lifting and carrying of items weighing 100 pounds (DX 6; *see also*, DX 53, p. 22; DX 62, pp. 14-15). Claimant has not been gainfully employed since leaving the coal mines on September 30, 1998 (DX 62, pp. 13; TR 27).

New Medical Evidence

As summarized below, the medical evidence includes various recent chest x-ray readings, pulmonary function studies, arterial blood gases, and physicians' opinions (including CT scan interpretations), which were obtained since the final denial of the prior claim, and submitted in connection with this subsequent claim.[3]

A. Chest X-rays

The record includes various interpretations of recent chest x-rays, as summarized below.[4]

Exhibit	Date	Physician	Classification	Quality
DX 13	1/25/02	Hussain	2/3, A	1
DX 14	1/25/02	Barrett	N.A.[5]	1
EX 2	1/25/02	Wiot	1/2, A	2
DX 46	1/3/03	Robinette	1/1, A	2
EX 2	1/3/03	Wiot	N.A.	Unreadable

[3] As previously noted, the only medical evidence from the prior claim was Dr. Sutherland's positive x-ray reading for simple pneumoconiosis, dated August 6, 1980, which has been accorded little weight (DX 1).

[4] In addition, the case file contains descriptive interpretations of chest x-rays, which do not conform with the classification requirements set forth in §718.102(b). (CX 2).

[5] Dr. Barrett, a B-reader and Board-certified radiologist, reread the January 25, 2002 x-ray for film quality only (DX 14).

EX 3	1/3/03	Broudy	N.A.	Unreadable
DX 58	2/17/03	Wicker	1/1, B	Not noted
EX 2	2/17/03	Wiot	1/2, A	2
EX 3	2/17/03	Broudy	1/0, A	1
EX 2	2/25/03	Wiot	N.A.	Unreadable
EX 2	5/13/03	Wiot	1/2, A	2
EX 2	7/7/03	Wiot	N.A.	Unreadable
CX 1	6/22/04	Forehand	1/1, A	1
EX 4	6/22/04	Wiot	2/1, 0	3

All of the foregoing physicians, except for Dr. Hussain are B-readers. In addition, Drs. Wiot and Barrett are Board-certified radiologists.

As discussed in the "Physician Opinions" and "Total Disability" sections of this decision, some of the foregoing physicians questioned whether the large opacities which were reported on almost all of the chest x-rays in evidence constitute complicated pneumoconiosis or some other abnormality. Furthermore, Dr. Wiot failed to find any large opacities on his rereading of the most recent film. However, I also note that Dr. Wiot reported the film quality as "3." In contrast, Dr. Wiot consistently found large opacities on chest x-rays which he found were of better quality. Moreover, the overwhelming majority of the x-ray evidence, including interpretations by multiple B-readers, is positive for *complicated* pneumoconiosis under the classification requirements set forth in §718.304(a). Accordingly, I find that Claimant has met his burden of establishing the presence of *complicated* pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies, dated January 25, 2002 (DX 13), January 3, 2003 (DX 46), February 17, 2003 (DX 58), and June 22, 2004 (CX 1), respectively. None of the studies are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. Accordingly, the pulmonary function studies do not support a finding of total (pulmonary or respiratory) disability.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on January 25, 2002 (DX 13), January 3, 2003 (DX 46), February 17, 2003 (DX 58), and July 2, 2004 (EX 3), respectively. The exercise blood gas study, dated January 25, 2002, is nonqualifying (DX 13). Furthermore, the February 17, 2003 resting blood gas test is marginally above the qualifying values (DX 46). On the other hand, the remaining arterial blood gas tests, including the most recent, are qualifying under the regulatory criteria stated in 20 C.F.R. Part 718, Appendix C (DX 13, 46; CX 1). In view of the foregoing, I find that the arterial blood gas studies support a finding of total (pulmonary or respiratory) disability.

D. Physicians' Opinions (including CT scan interpretations)

The case file includes descriptive CT scan interpretations by Drs. Younis (CX 2) and Antoun (CX 1); the reports and treatment records of Dr. Hussain (DX 13; CX 3); and, the other medical opinions of Drs. Robinette (DX 46), Wicker (DX 58), Broudy (EX 3), Forehand (CX 4, 5), and Wiot (EX 4).

Dr. Mark S. Younis, a radiologist at Appalachian Regional Healthcare, interpreted a CT scan, dated August 7, 2003 (CX 2). In summary, Dr. Younis stated:

> IMPRESSION
> Intrathoracic findings consistent with pneumoconiosis. In order to confirm stability, a short-term followup (sic) CT in three months is advised.

(CX 2).

Dr. Basim Antoun, a radiologist at "The Clinic, operated by Clinch Valley Physicians, Inc.," interpreted the CT scan, dated November 5, 2004 (CX 1). In summary, Dr. Antoun stated:

> **IMPRESSION:**
>
> Multiple large heavily calcified nodules in the right hemithorax are seen which in correlation with the chest x-ray of 06/22/04 and allowing for the variations in the x-ray technique do not appear to have significantly changed suggesting benign underlying process. The rest of the exam is otherwise unremarkable.

(CX 1).

Dr. Imtiaz Hussain, whose curriculum vitae is not in evidence, examined Claimant on January 25, 2002 (DX 13). Dr. Hussain completed a U.S. Department of Labor form report, in which he set forth Claimant's family, medical, and social histories, subjective complaints, physical findings on examination, and the results of clinical tests. In the "Summary of Results" section of the form report, Dr. Hussain set forth the following analysis of diagnostic tests administered on January 25, 2002:

Chest X-ray:	Pneumoconiosis.
Vent Study (PFS)	Normal.

Arterial Blood Gas Hypoxemia.
Other (EKG): Inferior T wave abnormalities

(DX 13, Sec. D5). Furthermore, under the "Cardiopulmonary Diagnoses" and etiology sections of the form report, Dr. Hussain diagnosed "Pneumoconiosis" due to "dust exposure." (DX 13, Sec. D6, 7). In addition, Dr. Hussain described the severity of Claimant's respiratory or pulmonary impairment as "moderate," without specifying whether Claimant could perform his last usual coal mine job (DX 13, Sec. D8). However, in conjunction with the January 25, 2002 report, Dr. Hussain also completed a questionnaire form on the same date (DX 13). Based upon his responses to various questions, and handwritten notations, Dr. Hussain opined that Claimant suffers from occupational lung disease caused by his coal mine employment based upon "x-ray findings, history of exposure." Furthermore, Dr. Hussain opined that Claimant suffers from a moderate pulmonary impairment due to pneumoconiosis. Finally, Dr. Hussain found that Claimant lacks the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment, because Claimant has "severe pneumoconiosis, hypoxemia." (DX 13).

The case file also includes Dr. Hussain's treatment notes covering the period from February 25, 2003 through October 14, 2004 (CX 2). Although the records are barely legible, they clearly include "black lung" among the diagnosed conditions (CX 2).

In a supplemental questionnaire form, signed on or about August 17, 2004, Dr. Hussain, again, responded to various questions (CX 3). Based upon his answers, Dr. Hussain stated that Claimant suffers from clinical pneumoconiosis and legal pneumoconiosis. Furthermore, Claimant's respiratory condition is significantly contributed to by coal dust. Moreover, Claimant is totally disabled due to pneumoconiosis. Furthermore, Claimant lacks the respiratory capacity to perform the work of a coal miner or comparable work in a dust-free environment, because he suffers from "severe dyspnea." Finally, the respiratory diagnosis found to be related to coal mine employment (*i.e.,* pneumoconiosis) has a material adverse effect on Claimant's pulmonary condition (CX 3).

Dr. Emory Robinette, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, examined Claimant on January 3, 2003 (DX 46). As stated above, Dr. Robinette found large opacities on Claimant's chest x-ray on that date. In his written report, Dr. Robinette set forth Claimant's history, subjective findings, review of systems, physical findings on examination, and, the results of various clinical tests, including chest x-ray, pulmonary function study, arterial blood gases, and EKG. Based upon the foregoing, Dr. Robinette stated, in pertinent part:

IMPRESSION:
1. Coal workers pneumoconiosis with multiple pulmonary nodules.
2. Dyspnea on exertion secondary to #1.

At the time of my evaluation Mr. Lester presented to the office with complaints of progressive shortness of breath and dyspnea. Historically he had worked in the mining industry for a total of 38 years and had substantial dust exposure. His chest x-ray showed

> evidence of dust reticulation but additionally showed rounded opacities in the right lower lung zones and the right upper lung zone consistent with either granulomatous lung disease versus possible pneumoconic nodules which were more rounded and atypical in their appearance. Subjectively he had dyspnea on exertion occurring as a consequence of his radiographic abnormalities which were superimposed on underlying emphysema. These findings are consistent with possible complicated coal workers' pneumoconiosis versus simple pneumoconiosis with granulomatous lung disease. Clearly his only documented exposure was the coal dust. I have requested additional x-rays for Mr. Lester for comparison to his current x-ray to ascertain if there has been interval change in his pulmonary nodules and the duration of his diagnosis.

(DX 46).

Dr. Mitchell Wicker, Jr., a B-reader, whose curriculum vitae is not in evidence, examined Claimant on February 17, 2003 (DX 58). Dr. Wicker completed a U.S. Department of Labor form report, in which he set forth Claimant's employment history, family, medical, and social histories, subjective complaints, physical findings on examination, and the results of clinical tests. In the "Summary of Results" section of the form report, Dr. Wicker set forth the following findings regarding clinical tests administered on January 25, 2002:

Chest X-ray:	Questionable Pneumoconiosis 1/1 Right Upper Zone Q/Q. Probably secondary to metastatic disease.
Vent Study (PFS)	Pre: FEV1 2.78 or 78%; MVV 62.65 or 43.8%; FVC 2.82 or 56%.
Arterial Blood Gas	Resting: pCO2 33.6, pO2 66.4, pH 7.412
Other:	EKG: Sinus rhythm at 65. PR interval at .16, QRS .08. Axis which is normal. Poor R-Wave Production.

(DX 58, Sec. D5). Under the "Cardiopulmonary Diagnoses" and etiology sections of the form report, Dr. Wicker diagnosed "Questionable Pneumoconiosis 1/1 Right Upper Zone Q/Q. Probably secondary to metastatic disease." Furthermore, he reported "Not Applicable" regarding the etiology of such condition (DX 58, Sec. D6, 7). In addition, when asked the severity of Claimant's respiratory impairment, in conjunction with his ability to perform his last coal mine job, Dr. Wicker stated: "This individual's respiratory capacity appears to be mildly diminished etiology is unclear to perform his duties in the coal mining industry." (sic). (DX 58, Sec. D8).

Dr. Bruce C. Broudy, a B-reader who is Board-certified in Internal Medicine and Pulmonary Medicine, issued a report, dated July 7, 2003, in which he reviewed various medical data, including a report by Dr. Simpao which is not in evidence (EX 3). Dr. Broudy also cited the findings and clinical data obtained by Drs. Hussain, Wicker, and Robinette. He also noted that Claimant's work history included a total of 34 years in coal mining. In conclusion, Dr. Broudy stated:

> The above summarizes the evidence. All of the x-ray interpretations were positive for pneumoconiosis, although there is a great spread from 1/0 to 2/3. This may be in part due to variation [in] film quality, but suggests that there also was definite variation of the readers interpretations.

> The fact that spirometry was normal on the valid studies, and that the blood gases showed mild to moderate hypoxemia, it is my opinion that the patient did not have disabling respiratory impairment. If he has pneumoconiosis it would be simple pneumoconiosis. I would be interested in reviewing additional x-rays or previous x-rays so that I could make my own determination about the abnormalities on chest x-ray. I would be happy to review additional films.
>
> With regards to Mr. Lester's symptoms, I believe that all of his symptoms are unrelated pneumoconiosis. One would not expect symptoms due to coal workers' pneumoconiosis unless one had significant impairment on ventilatory studies, and this is not the case in this situation.

(EX 3).

In a supplemental report, dated September 4, 2003 (EX 3), Dr. Broudy summarized his own x-rays interpretations of the films, dated January 3, 2003 and February 17, 2003. Dr. Broudy reported that the former was unreadable. Dr. Broudy described his findings on the February 17, 2003 x-ray, in pertinent part, as follows:

> There are nodular opacities in all zones which I think are consistent with early simple pneumoconiosis. I would categorize the film as Category 1/0, q/p. There are some rounded nodular opacities in the right lower zone and an irregular opacity in the right upper zone. The upper zone lesion could be a lesion of complicated pneumoconiosis or coalescence of nodulation. There is no pleural disease. The lung zones are otherwise clear. The nodules in the lower zone are suspicious for neoplasm.

(EX 3). In addition, Dr. Broudy addressed questions posed regarding his analysis of Claimant's pulmonary condition, stating, in pertinent part:

> In response to your letter of July 16, 2003 you have asked me to give some documentation for my claim that this individual's symptoms are not due to pulmonary disease and specifically coal workers' pneumoconiosis. My review of the previous evidence showed that spirometry was normal on two occasions and invalid on the third. Blood gases showed mild to moderate hypoxemia, but the saturation of oxygen was never low enough to cause symptomatology. My statement merely reflects that symptoms due to lung disease are usually associated with functional impairment of the organ. Without any significant functional impairment, as noted by the normal spirometry and mild to moderate hypoxemia, it would be difficult to attribute the symptoms to pulmonary disease of any type. This would include coal workers' pneumoconiosis or silicosis. The fact that he does have some interstitial disease on chest x-ray does not mean necessarily that symptoms are due to the presence of the abnormality found on the x-rays. I am not saying it is impossible that the symptoms are due to his coal workers' pneumoconiosis, but I am saying it is unlikely that dyspnea would be due to lung disease with normal spirometry. Furthermore, it is possible that the coughing could be related to interstitial lung disease such as is caused by coal workers' pneumoconiosis. These statements are

well documented by the chapters on pneumoconiosis in well recognized authoritative reference on occupational lung diseases such as the book Occupational Lung Diseases, 3rd edition, by Morgan & Seaton.

(EX 3).

Dr. J. Randolf Forehand is a B-reader who is Board-certified in Allergy & Immunology, as well as Pediatrics (CX 1; EX 4). Dr. Forehand examined Claimant on June 22, 2004, and issued a "Pulmonary Evaluation" report on that date (CX 1). Dr. Forehand set forth Claimant's occupational history, past medical history, family history, social history, findings on physical examination, and, clinical data. The latter included the following results:

> **LABORATORY DATA:**
> A chest x-ray has generalized reticulonodular fibrosis. A mass is noted in the right upper lung zone. A spirogram shows a normal ventilatory pattern. DLCO normal. An arterial blood gas has a pH of 7.41, pO2 69, pCO2 31 and an AA gradient of 29%, indicative of arterial hypoxemia. An electrocardiogram shows no acute changes.

(CX 1). Furthermore, Dr. Forehand reported the following:

> **IMPRESSION:**
>
> 1. Coal workers' pneumoconiosis.
> 2. Work-limiting respiratory impairment of a gas-exchange nature.

(CX 1).

In a supplemental letter, dated August 21, 2004, Dr. Forehand stated that he had examined Claimant on June 22, 2004, and that the chest x-ray was consistent with complicated coal workers' pneumoconiosis. Nevertheless, Dr. Forehand recommended a CT scan to rule out other possible causes (CX 4).

In a supplemental report, dated November 12, 2004 (CX 1), Dr. Forehand stated:

> Mr. Lester is a 57-year-old disabled coal miner with complicated coal workers' pneumoconiosis and progressive massive fibrosis of the lungs who was seen in my office on June 22, 2004 [to] further explain his complaints of shortness of breath on exertion and to define the extent of the damage to Mr. Lester's lungs from 33 years exposure to coal mine dust as an underground coal miner.
>
> Mr. Lester's chest X-ray (06/22/04) shows a background of coal workers' pneumoconiosis with superimposed large masses indicative of progressive massive fibrosis. An enhanced CT scan of Mr. Lester's chest (11/05/04) confirms these findings and rules out malignancy and cavitary tuberculosis. Mr. Lester's spirogram and DLCO were normal, which is not surprising since Mr. Lester did not smoke cigarettes. On the

other hand, the arterial blood gas study (06/22/04) was abnormal. The oxygen level (pO2) was 69 indicative of arterial hypoxemia

Based on my findings and criteria established by the U.S. Department of Labor, the American Medical Association, and the American Thoracic Society, Mr. Lester had a totally and permanently disabling respiratory impairment, which arose from his 33-year employment in underground coal mining and complicated coal workers' pneumoconiosis and which would prevent him from returning to his last coal mining job.

(CX 1). (Footnotes-Citing Federal regulations and medical literature omitted).

Dr. Jerome F. Wiot, a B-reader and Board-certified radiologist (EX 2), issued a report, dated November 4, 2004, in which he reviewed CT scans dated January 19, 1999 and August 7, 2003 (EX 2). Dr. Wiot stated, in pertinent part:

Both CT scans show evidence of simple coal worker's pneumoconiosis. However, in addition, there are granulomas with central calcification present within the right upper lobe and two similar granulomas with central calcification present within the right lower lobe. This is not a manifestation of coal dust exposure. They contain a central nidus of calcification, as well are well-defined and are totally consistent with calcified granulomas. The CT study of 08-07-03 also shows diffuse small opacities consistent with simple coal worker's pneumoconiosis as well as the granulomas originally described. This is not a manifestation of coal dust exposure. They are secondary to some form of granulomatous disease, either histoplasmosis or tuberculosis. As stated, this is not a manifestation of coal dust exposure.

CT is medically acceptable for evaluation of pulmonary problems. CT is beneficial in confirming or denying the presence of simple coal worker's pneumoconiosis, and can be beneficial in recognizing complicated coal worker's pneumoconiosis when it is not evident on the routine chest xrays (sic).

In summary, there are findings compatible with simple coal worker's pneumoconiosis by chest CT. There is no evidence of large opacities seen on these CT scans.

(EX 2).

In a supplemental report, dated January 11, 2005, Dr. Wiot reviewed his CT scan, dated November 5, 2004 (EX 4). Dr. Wiot state, in pertinent part:

There are definite small opacities, greater on the right than on the left, more in the upper lung fields than in the lower fields. These findings are compatible with simple coal worker's pneumoconiosis. There are masses noted with definite central calcification. The calcification on a couple of them appears somewhat popcorn-like, which would strongly suggest that these represent hamartomas. This is not a manifestation of coal dust exposure. The CT is otherwise unremarkable.

> CT is medically acceptable for evaluation of pulmonary problems. CT is beneficial in confirming or denying the presence of simple coal worker's pneumoconiosis, and can be beneficial in recognizing complicated coal worker's pneumoconiosis when it is not evident on the routine chest xrays (sic).
>
> In summary, this patient shows findings compatible with simple coal worker's pneumoconiosis by CT scan. There is no evidence of complicated coal worker's pneumoconiosis.

(EX 4).

In a supplemental report, dated February 3, 2005, Dr. Wiot responded to a request by Employer's counsel to comment on Dr. Forehand's reports and to address the question of whether there is any causal connection between the findings and Claimant's coal mine employment. In response thereto, Dr. Wiot stated that he lacked the pulmonary expertise to address these issues (EX 4).

On the other hand, Dr. Forehand addressed Dr. Wiot's radiological interpretations, in a supplemental report, dated February 18, 2005 (CX 5), stating:

> I have read Dr. Jerome Wiot's 1/11/05 interpretation of Mr. Lester's chest X-ray dated June 22, 2004 previously read by me as showing complicated coal workers' pneumoconiosis and his 1/11/05 interpretation of a CT scan of Mr. Lester's chest dated November 5, 2004 previously interpreted as confirming the presence of complicated coal workers' pneumoconiosis.
>
> When Dr. Wiott (sic) opined that Mr. Lester's chest X-ray was more compatible with calcified granuloma he did not take into consideration that Mr. Lester does not have nor has he ever had pulmonary tuberculosis or other pulmonary infection resulting in large bilateral upper lobe masses. Likewise, when Dr. Wiott (sic) opined that Mr. Lester's chest X-ray (sic) was more compatible with hamartomas he did not take into consideration that hamartomas arise on only one side and are rounded, smooth masses with cartilage and remnants of other body tissues.
>
> Dr. Wiott's (sic) reports do not change my opinion that Mr. Lester has complicated coal workers' pneumoconiosis and not pulmonary tuberculosis or a pulmonary hamartoma.

(CX 5).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of x-ray evidence. As stated above, the case file contains numerous x-ray interpretations by B-readers and/or Board-

certified radiologists which establish simple and complicated pneumoconiosis under the classification requirements set forth in §718.102(b) and §718.304(a), respectively. Moreover, all of the x-ray readings are positive for at least simple pneumoconiosis. Accordingly, I find that Claimant has clearly established the presence of pneumoconiosis pursuant to §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. As discussed below, I find that the presumption of §718.304 does apply because complicated pneumoconiosis has been established by a preponderance of the evidence. Therefore, Claimant has also established pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 as a chronic dust disease of the lung, including respiratory or pulmonary impairments arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.201(a)(1) and (2).

As outlined above, virtually all of the physicians who addressed the "pneumoconiosis" issue found that Claimant has, at least, simple pneumoconiosis. In view of the foregoing, I find that Claimant has also established the presence of pneumoconiosis under §718.202(a)(4).

Pursuant to the holding of the Fourth Circuit, I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. In summary, I find that the x-ray evidence and medical opinion evidence (including CT scan interpretations) establish the presence of pneumoconiosis. Therefore, I find that pneumoconiosis has been established under 20 C.F.R. §718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203. This presumption has not been rebutted.

Total Disability

The regulations provide that a claimant may be entitled to an irrebuttable presumption of total disability due to pneumoconiosis, if he can establish the presence of *complicated* pneumoconiosis under §718.304.

As stated above, almost all of the *readable* chest x-ray interpretations, including those by B-readers and/or Board-certified radiologists, are positive for *complicated* pneumoconiosis under the classification requirements set forth in §718.304(a). Moreover, I accord little weight to Dr. Wiot's interpretation of the chest x-ray, dated June 22, 2004, because he reported the film quality as "3." In contrast, Dr. Wiot, as well as other physicians of record, found large opacities on better quality films.

Some of the physicians who reported large opacities questioned whether they represent complicated pneumoconiosis or some other condition. For example, Dr. Robinette reported findings "consistent with possible complicated coal workers' pneumoconiosis versus simple pneumoconiosis with granulomatous disease." (DX 46). Drs. Wicker and Broudy noted "ca" (*i.e.,* cancer). (DX 58; EX 3). Furthermore, Dr. Wiot stated that the large opacities on the chest x-ray, dated January 25, 2002, "may represent a carcinoma" (EX 2). On the February 17, 2003 film, Dr. Wiot reported "masses RLL" (EX 2). On the May 13, 2003, Dr. Wiot noted: "R/O Malignancy. Mass RUL may not be large opacity (EX 2).

In summary, I find that the overwhelming preponderance of the x-ray evidence is positive for complicated pneumoconiosis under the classification requirements set forth in §718.304(a). Furthermore, as discussed below, I accord little weight to the alternative diagnoses cited by various physicians. Accordingly, I find that Claimant has met his burden of establishing the presence of *complicated* pneumoconiosis by a preponderance of the x-ray evidence. Therefore, Claimant has established the presence of *complicated* pneumoconiosis under §718.304(a).

In the absence of any biopsy or autopsy evidence, Claimant cannot establish the presence of massive lesions in the lung or complicated pneumoconiosis under §718.304(b).

Pursuant to §718.304(c), complicated pneumoconiosis may be diagnosed by means other than those specified in paragraphs (a) or (b), provided that the diagnosis is made in accordance with acceptable medical procedures, and, it "would be a condition which could reasonably be expected to yield the results described in paragraphs (a) or (b) of §718.304.

As summarized above, the record contains descriptive CT scan interpretations by Drs. Younis (CX 2) and Antoun (CX 1); the reports and treatment records of Dr. Hussain (DX 13; CX 3); and, the opinions of Drs. Robinette (DX 46), Wicker (DX 58), Broudy (EX 3), Forehand (CX 4, 5), and Wiot (EX 4).

The descriptive interpretations of Drs. Younis and Antoun are insufficient, in and of themselves, to establish the presence of complicated pneumoconiosis. I note, however, that Dr. Younis' reading of the CT scan, dated August 7, 2003, was "consistent with pneumoconiosis." Furthermore, he noted some larger nodules but did not specify their size. Moreover, Dr. Younis' CT scan interpretation was done in conjunction with Claimant's treatment by Dr. Imitiaz Hussain. In his findings, Dr. Younis expressly stated that he did not see a unilateral suspicious nodule to warrant biopsy. This tends to undermine the opinions of those physicians who suspected that the large opacities were malignant masses and/or cancer (CX 2). Similarly, Dr. Antoun, who interpreted the CT scan, dated November 5, 2004, found no significant changes "suggesting benign underlying process." In addition, Dr. Antoun reported "three relatively large

calcified nodules" which were 2 or more centimeters in size. However, absent a specific statement that this would appear greater than 1 centimeter on chest x-ray and/or that these constitute massive lesions in the lungs, Dr. Antoun's CT scan interpretation, in and of itself, does not establish complicated pneumoconiosis under §718.304(b).

Dr. Hussain's treatment records and medical reports, if credited, clearly support a finding that Claimant suffers from totally disabling pneumoconiosis. However, Dr. Hussain's reports do not directly address the complicated pneumoconiosis issue (DX 13; CX 3). Dr. Robinette's report is inconclusive regarding the presence or absence of complicated pneumoconiosis. Although he found that Claimant suffers from dyspnea on exertion secondary to pneumoconiosis, he failed to specifically address the question of whether Claimant suffers from a totally disabling pulmonary or respiratory impairment (DX 46). Dr. Wicker reported questionable pneumoconiosis, and suggested that the large opacities shown on chest x-ray are probably secondary to metastatic cancer. His reported assessment of Claimant's pulmonary or respiratory impairment is ambiguous (DX 58). Dr. Broudy acknowledged that the upper zone lesion could be complicated pneumoconiosis or a coalescence of nodulation. Although Dr. Broudy initially stated that all of Claimant's symptoms are unrelated to pneumoconiosis, he subsequently acknowledged that he could not say it is impossible that the symptoms are due to his coal workers' pneumoconiosis. Furthermore, based upon normal spirometry and :mild to moderate hypoxemia on arterial blood gases, Dr. Broudy opined that Claimant does not suffer from a disabling respiratory impairment (EX 3). Dr. Wiot did not address the question of whether Claimant suffers from a totally disabling pulmonary impairment (EX 4). However, Dr. Wiot found that Claimant does not suffer from complicated pneumoconiosis, despite finding large opacities on the better quality films. As stated above, Dr. Wiot's x-ray readings indicated that he felt that there may be a metastatic mass or cancer. On the other hand, Dr. Wiot's CT scan interpretations indicated that he questioned whether there were large opacities. Furthermore, Dr. Wiot suggested various other possible etiologies for the large nodules found on x-ray and CT scan, including histoplasmosis or tuberculosis (EX 2), or hamartomas (EX 4). Finally, Dr. Forehand's opinion, if credited, establishes that Claimant suffers from complicated pneumoconiosis and that he suffers from a totally disabling pulmonary or respiratory disability due to pneumoconiosis. Furthermore, Dr. Forehand questioned the alternative diagnoses cited by Dr. Wiot (CX 1, 4, 5).

Having carefully weighed the conflicting medical opinion evidence (including the CT scan interpretations), I accord the most weight to Dr. Forehand's opinion. As stated above, Dr. Forehand is a B-reader who is Board-certified in Allergy & Immunology, as well as Pediatrics. Thus, Dr. Forehand lacks the Board-certification in Radiology of Dr. Wiot, and, the Board-certification in Pulmonary Medicine of Drs. Robinette and Broudy. Therefore, if my determination were based solely on the relative credentials of the respective physicians, I would not find Dr. Forehand's opinion most persuasive. However, in making my determination herein, I find that Dr. Forehand's opinion is most probative because it is well-reasoned, well-documented, unambiguous, and most consistent with Claimant's 32+ years of coal mine employment, the absence of any smoking history, the large opacities found on multiple chest x-rays by numerous B-reader and/or Board-certified radiologists, the abnormalities on CT scans, the absence of any evidence of cancer, tuberculosis, histoplasmosis, or hamartomas in the treatment records, the preponderance of the qualifying arterial blood gas evidence, and

Claimant's complaints of dyspnea, notwithstanding nonqualifying pulmonary function results. In addition, Dr. Forehand's total disability finding is partially buttressed by the opinion of Dr. Hussain, Claimant's treating physician. I note, however, that Dr. Hussain's credentials are not in evidence. Moreover, I find that his reports are somewhat cursory. Therefore, Dr. Hussain's opinion is accorded somewhat less weight than that of Dr. Forehand. In summary, I find that Claimant has established the presence of *complicated* pneumoconiosis under §718.304(c) and total disability due to pneumoconiosis under §718.204(b)(iv) and §718.204(c), respectively.

Assuming *arguendo* that Claimant had not established complicated pneumoconiosis under §718.304, the regulations also provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the pulmonary function studies are not qualifying under the applicable regulatory criteria set forth in Part 718, Appendix B. Therefore, Claimant has not established total disability pursuant to §718.204(b)(2)(i). However, the preponderance of the arterial blood gas study evidence is qualifying. Therefore, Claimant has established total disability under §718.204(b)(2)(ii).

Since the record does not establish the presence of cor pulmonale with right-sided heart failure, Claimant cannot establish total disability pursuant §718.204(b)(2)(iii). However, as set forth above, I find that the better reasoned medical opinion evidence establishes that Claimant suffers from a totally disabling pulmonary or respiratory impairment. Therefore, Claimant has also established total disability under §718.204(b)(2)(iv).

Having weighed all of the evidence, like and unlike, I find that despite the nonqualifying pulmonary function studies, the qualifying arterial blood gas evidence and more probative medical opinion evidence establish that Claimant does suffers from a totally disabling pulmonary or respiratory impairment. 20 C.F.R. §718.204(b).

Total Disability Due to Pneumoconiosis

Since Claimant has established *complicated* pneumoconiosis under §718.304, he is entitled to the irrebuttable presumption that his total disability is due to pneumoconiosis. 20 C.F.R. §718.304. Moreover, assuming *arguendo* that Claimant failed to establish complicated pneumoconiosis, I find that the better reasoned medical opinion evidence establishes that Claimant's total (pulmonary or respiratory) disability is due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Having considered the relevant evidence, I find that Claimant has established the presence of *complicated* pneumoconiosis which arose out of his 32+ years of coal mine employment. Moreover, even without the benefit of the irrebuttable presumption of total disability due to pneumoconiosis, I find that Claimant has also established that he suffers from a totally disabling pulmonary or respiratory impairment due to pneumoconiosis. Therefore, Claimant has clearly demonstrated a material change in conditions under §725.309, and all of the necessary elements of entitlement. Accordingly, Claimant is eligible for benefits under the Act and regulations.

Commencement of Entitlement to Benefits

Since the evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, I find that benefits shall commence effective October 1, 2001, beginning with the month during which the miner filed his claim. 20 C.F.R. §725.503(b).

Attorney's Fees

No award of attorney's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

It is ordered that the claim of Tolby Lester for benefits under the Black Lung Benefits Act is hereby **GRANTED**.

It is further ordered that the Employer, K & N Coal Company, shall pay to the Claimant all benefits to which he is entitled under the Act, augmented by reason of his dependent spouse, as heretofore specified, commencing as of October 1, 2001.

It is further ordered that the Employer, K & N Coal Company, shall reimburse the Secretary of Labor for payments made under the Act to Tolby Lester, if any, and deduct

such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph above.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.